

EXHIBIT 10

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Gender Affirming Surgery

[Clinical Policy Bulletins](#) | [Medical Clinical Policy Bulletins](#)**Number: 0615**

Policy

Aetna considers gender affirming surgery medically necessary when all of the following criteria are met:

I. Requirements for breast removal:

- A. Single letter of referral from a qualified mental health professional (see Appendix); *and*
- B. Persistent, well-documented gender dysphoria (see Appendix); *and*
- C. Capacity to make a fully informed decision and to consent for treatment; *and*
- D. For members less than 18 years of age, completion of one year of testosterone treatment; *and*
- E. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note: A trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy in adults.

II. Requirements for breast augmentation (implants/lipofilling):

Policy History

[Last Review](#)

01/12/2021

Effective: 05/14/2002

Next Review: 06/24/2021

[Review History](#) [Definitions](#)

Additional Information

[Clinical Policy Bulletin](#)[Notes](#)

State Information

[California](#) **Exhibit
0030**9/30/2021
Dr. Lappert

- A. Single letter of referral from a qualified mental health professional (see Appendix); *and*
- B. Persistent, well-documented gender dysphoria (see Appendix); *and*
- C. Capacity to make a fully informed decision and to consent for treatment; *and*
- D. Member is 18 years of age or older; *and*
- E. Completion of one year of feminizing hormone therapy prior to breast augmentation surgery (unless the member has a medical contraindication or is otherwise medically unable to take hormones); *and*
- F. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note: More than one breast augmentation is considered not medically necessary. This does not include the medically necessary replacement of breast implants (see [CPB 0142 - Breast Implant Remova \(./100_199/0142.html\)](#))).

III. Requirements for gonadectomy (hysterectomy and oophorectomy or orchiectomy):

- A. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); *and*
- B. Persistent, well-documented gender dysphoria (see Appendix); *and*
- C. Capacity to make a fully informed decision and to consent for treatment; *and*
- D. Age 18 years or older; *and*
- E. If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
- F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones).

IV. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis and erectile prosthesis,

penectomy, vaginoplasty, labiaplasty, and clitoroplasty)

- A. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); *and*
- B. Persistent, well-documented gender dysphoria (see Appendix); *and*
- C. Capacity to make a fully informed decision and to consent for treatment; *and*
- D. Age 18 years and older; *and*
- E. If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
- F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); *and*
- G. Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

Note on gender specific services for the transgender community:

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for transmasculine persons who have not undergone chest masculinization surgery;
2. Prostate cancer screening may be medically necessary for transfeminine persons who have retained their prostate.

Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria (see [CPB 0501 - Gonadotropin-Releasing Hormone Analogs and Antagonists \(../500_599/0501.html\)](#)).

Aetna considers reversal of gender affirming surgery for gender dysphoria not medically necessary.

Aetna considers the following procedures that may be performed as a component of a gender transition as cosmetic (not an all-inclusive list) (see also [CPB 0031 - Cosmetic Surgery \(./1_99/0031.html\)](#)):

- Abdominoplasty
- Blepharoplasty
- Body contouring (liposuction of waist)
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Construction of a clitoral hood
- Drugs for hair loss or growth
- Face lifting
- Facial bone reduction
- Facial feminization and masculinization surgery
- Feminization of torso
- Forehead lift
- Jaw reduction (jaw contouring)
- Hair removal (e.g., electrolysis, laser hair removal) (Exception:
A limited number of electrolysis or laser hair removal sessions are considered medically necessary for skin graft preparation for genital surgery)
- Hair transplantation
- Lip enhancement
- Lip reduction
- Liposuction
- Masculinization of torso
- Mastopexy
- Neck tightening
- Nipple reconstruction
- Nose implants
- Pectoral implants
- Pitch-raising surgery
- Removal of redundant skin
- Rhinoplasty
- Skin resurfacing (dermabrasion/chemical peel)

- Tracheal shave (reduction thyroid chondroplasty)
- Voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords)
- Voice therapy/voice lessons.

Background

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between an individual's gender identity and the gender assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). A diagnosis of gender dysphoria requires a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. This condition may cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender affirming surgery is performed to change primary and/or secondary sex characteristics. For transfeminine (assigned male at birth) gender transition, surgical procedures may include genital reconstruction (vaginoplasty, penectomy, orchidectomy, clitoroplasty), breast augmentation (implants, lipofilling), and cosmetic surgery (facial reshaping, rhinoplasty, abdominoplasty, thyroid chondroplasty (laryngeal shaving), voice modification surgery (vocal cord shortening), hair transplants) (Day, 2002). For transmasculine (assigned female at birth) gender transition, surgical procedures may include mastectomy, genital reconstruction (phalloplasty, genitoplasty, hysterectomy, bilateral oophorectomy), mastectomy, and cosmetic procedures to enhance male features such as pectoral implants and chest wall recontouring (Day, 2002).

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery (Coleman, et al., 2011).

It is recommended that transfeminine persons undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

In addition to hormone therapy and gender affirming surgery, psychological adjustments are necessary in affirming sex. Treatment should focus on psychological adjustment, with hormone therapy and gender affirming surgery being viewed as confirmatory procedures dependent on adequate psychological adjustment. Mental health care may need to be continued after gender affirming surgery. The overall success of treatment depends partly on the technical success of the surgery, but more crucially on the psychological adjustment of the trans identified person and the support from family, friends, employers and the medical profession.

Nakatsuka (2012) noted that the third versions of the guideline for treatment of people with gender dysphoria (GD) of the Japanese Society of Psychiatry and Neurology recommends that feminizing/masculinizing hormone therapy and genital surgery should not be carried out until 18 years old and 20 years old, respectively. On the other hand, the sixth (2001) and the seventh (2011) versions of the standards of care for the health of transsexual, transgender, and gender non-conforming people of World Professional Association for Transgender Health (WPATH) recommend that transgender adolescents (Tanner stage 2, [mainly 12 to 13 years of age]) are treated by the endocrinologists to suppress puberty with gonadotropin-releasing hormone (GnRH) agonists until age 16 years old, after which gender-affirming hormones may be given. A questionnaire on 181 people with GID diagnosed in the Okayama University Hospital (Japan) showed that female to male (FTM) trans identified individuals hoped to begin masculinizing hormone therapy at age of 15.6 +/- 4.0 (mean +/- S.D.) whereas male to female (MTF) trans identified individuals hoped to begin feminizing hormone therapy as early as age 12.5 +/- 4.0, before presenting secondary sex characters. After confirmation of strong and persistent trans gender identification, adolescents with GD should be treated with gender-affirming hormone or puberty-delaying hormone to prevent developing undesired sex

characters. These treatments may prevent transgender adolescents from attempting suicide, suffering from depression, and refusing to attend school.

Spack (2013) stated that GD is poorly understood from both mechanistic and clinical standpoints. Awareness of the condition appears to be increasing, probably because of greater societal acceptance and available hormonal treatment. Therapeutic options include hormone and surgical treatments but may be limited by insurance coverage because costs are high. For patients seeking MTF affirmation, hormone treatment includes estrogens, finasteride, spironolactone, and GnRH analogs. Surgical options include feminizing genital and facial surgery, breast augmentation, and various fat transplantations. For patients seeking a FTM gender affirmation, medical therapy includes testosterone and GnRH analogs and surgical therapy includes mammoplasty and phalloplasty. Medical therapy for both FTM and MTF can be started in early puberty, although long-term effects are not known. All patients considering treatment need counseling and medical monitoring.

Leinung and colleagues (2013) noted that the Endocrine Society's recently published clinical practice guidelines for the treatment of transgender persons acknowledged the need for further information on transgender health. These investigators reported the experience of one provider with the endocrine treatment of transgender persons over the past 2 decades. Data on demographics, clinical response to treatment, and psychosocial status were collected on all transgender persons receiving gender-affirming hormone therapy since 1991 at the endocrinology clinic at Albany Medical Center, a tertiary care referral center serving upstate New York. Through 2009, a total 192 MTF and 50 FTM transgender persons were seen. These patients had a high prevalence of mental health and psychiatric problems (over 50 %), with low rates of employment and high levels of disability. Mental health and psychiatric problems were inversely correlated with age at presentation. The prevalence of gender affirming surgery was low (31 % for MTF). The number of persons seeking treatment has increased substantially in recent years. Gender-affirming hormone therapy achieves very good results in FTM persons and is most successful in MTF persons when initiated at younger ages. The authors concluded that transgender persons seeking hormonal therapy are being seen with increasing

frequency. The dysphoria present in many transgender persons is associated with significant mood disorders that interfere with successful careers. They stated that starting therapy at an earlier age may lessen the negative impact on mental health and lead to improved social outcomes.

Meyer-Bahlburg (2013) summarized for the practicing endocrinologist the current literature on the psychobiology of the development of gender identity and its variants in individuals with disorders of sex development or with transgenderism. Gender reassignment remains the treatment of choice for strong and persistent gender dysphoria in both categories, but more research is needed on the short-term and long-term effects of puberty-suppressing medications and cross-sex hormones on brain and behavior.

Irreversible Surgical Interventions for Minors

The World Professional Association for Transgender Health (WPATH) recommendations version 7 (Coleman, et al., 2011) states, regarding irreversible surgical interventions, that "[g]enital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention." The WPATH guidelines state that "Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression."

Note on Breast Reduction/Mastectomy and Nipple Reconstruction

The CPT codes for mastectomy (CPT codes 19303 and 19304) are for breast cancer, and are not appropriate to bill for reduction mammoplasty for female to male (transmasculine) gender affirmation surgery. CPT 2020

states that "Mastectomy procedures (with the exception of gynecomastia [19300]) are performed either for treatment or prevention of breast cancer." CPT 2020 also states that "Code 19303 describes total removal of ipsilateral breast tissue with or without removal of skin and/or nipples (eg, nipple-sparing), for treatment or prevention of breast cancer." There are important differences between a mastectomy for breast cancer and a mastectomy for gender reassignment. The former requires careful attention to removal of all breast tissue to reduce the risk of cancer. By contrast, careful removal of all breast tissue is not essential in mastectomy for gender reassignment. In mastectomy for gender reassignment, the nipple areola complex typically can be preserved.

Some have tried to justify routinely billing CPT code 19350 for nipple reconstruction at the time of mastectomy for gender reassignment based upon the frequent need to reduce the size of the areola to give it a male appearance. However, the nipple reconstruction as defined by CPT code 19350 describes a much more involved procedure than areola reduction. The typical patient vignette for CPT code 19350, according to the AMA, is as follows: "The patient is measured in the standing position to ensure even balanced position for a location of the nipple and areola graft on the right breast. Under local anesthesia, a Skate flap is elevated at the site selected for the nipple reconstruction and constructed. A full-thickness skin graft is taken from the right groin to reconstruct the areola. The right groin donor site is closed primarily in layers."

The AMA vignette for CPT code 19318 (reduction mammoplasty) clarifies that this CPT code includes the work that is necessary to reposition and reshape the nipple to create an aesthetically pleasing result, as is necessary in female to male breast reduction. "The physician reduces the size of the breast, removing wedges of skin and breast tissue from a female patient. The physician makes a circular skin incision above the nipple, in the position to which the nipple will be elevated. Another skin incision is made around the circumference of the nipple. Two incisions are made from the circular cut above the nipple to the fold beneath the breast, one on either side of the nipple, creating a keyhole shaped skin and breast incision. Wedges of skin and breast tissue are removed until the desired size is achieved. Bleeding vessels may be ligated or cauterized. The physician elevates the nipple and its pedicle of subcutaneous tissue to its new position and sutures the nipple pedicle

with layered closure. The remaining incision is repaired with layered closure" (EncoderPro, 2019). CPT code 19350 does not describe the work that that is being done, because that code describes the actual construction of a new nipple.

Thus, Aetna considers nipple reconstruction, as defined by CPT code 19350, as cosmetic/not medically necessary for mastectomy for transmasculine gender reassignment, and that CPT code 19318 includes the extra work that may be necessary to reshape the nipple and create an aesthetically pleasing male chest.

Vulvoplasty versus Vaginoplasty as Gender-Affirming Genital Surgery for Transgender Women

Jiang and colleagues (2018) noted that gender-affirming vaginoplasty aims to create the external female genitalia (vulva) as well as the internal vaginal canal; however, not all patients desire nor can safely undergo vaginal canal creation. These investigators described the factors influencing patient choice or surgeon recommendation of vulvoplasty (creation of the external appearance of female genitalia without creation of a neovaginal canal) and evaluated the patient's satisfaction with this choice. Gender-affirming genital surgery consults were reviewed from March 2015 until December 2017, and patients scheduled for or who had completed vulvoplasty were interviewed by telephone. These investigators reported demographic data and the reasons for choosing vulvoplasty as gender-affirming surgery for patients who either completed or were scheduled for surgery, in addition to patient reports of satisfaction with choice of surgery, satisfaction with the surgery itself, and sexual activity after surgery. A total of 486 patients were seen in consultation for trans-feminine gender-affirming genital surgery: 396 requested vaginoplasty and 39 patients requested vulvoplasty; 30 Patients either completed or are scheduled for vulvoplasty. Vulvoplasty patients were older and had higher body mass index (BMI) than those seeking vaginoplasty. The majority (63 %) of the patients seeking vulvoplasty chose this surgery despite no contraindications to vaginoplasty. The remaining patients had risk factors leading the surgeon to recommend vulvoplasty. Of those who completed surgery, 93 % were satisfied with the surgery and their decision for vulvoplasty. The authors concluded that this was the first study of factors impacting a patient's choice of or a

surgeon's recommendation for vulvoplasty over vaginoplasty as gender-affirming genital surgery; it also was the first reported series of patients undergoing vulvoplasty only.

Drawbacks of this study included its retrospective nature, non-validated questions, short-term follow-up, and selection bias in how vulvoplasty was offered. Vulvoplasty is a form of gender-affirming feminizing surgery that does not involve creation of a neovagina, and it is associated with high satisfaction and low decision regret.

Autologous Fibroblast-Seeded Amnion for Reconstruction of Neovagina in Transfeminine Reassignment Surgery

Seyed-Forootan and colleagues (2018) stated that plastic surgeons have used several methods for the construction of neo-vaginas, including the utilization of penile skin, free skin grafts, small bowel or recto-sigmoid grafts, an amnion graft, and cultured cells. These researchers compared the results of amnion grafts with amnion seeded with autograft fibroblasts. Over 8 years, these investigators compared the results of 24 male-to-female transsexual patients retrospectively based on their complications and levels of satisfaction; 16 patients in group A received amnion grafts with fibroblasts, and the patients in group B received only amnion grafts without any additional cellular lining. The depths, sizes, secretions, and sensations of the vaginas were evaluated. The patients were monitored for any complications, including over-secretion, stenosis, stricture, fistula formation, infection, and bleeding. The mean age of group A was 28 ± 4 years and group B was 32 ± 3 years. Patients were followed-up from 30 months to 8 years (mean of 36 ± 4) after surgery.

The depth of the vaginas for group A was 14 to 16 and 13 to 16 cm for group B. There was no stenosis in neither group. The diameter of the vaginal opening was 34 to 38 mm in group A and 33 to 38 cm in group B.

These researchers only had 2 cases of stricture in the neo-vagina in group B, but no stricture was recorded for group A. All of the patients had good and acceptable sensation in the neo-vagina; 75 % of patients had sexual experience and of those, 93.7 % in group A and 87.5% in group B expressed satisfaction. The authors concluded that the creation of a neo-vaginal canal and its lining with allograft amnion and seeded autologous fibroblasts is an effective method for imitating a normal vagina. The size of neo-vagina, secretion, sensation, and orgasm was good and proper.

More than 93.7 % of patients had satisfaction with sexual intercourse.

They stated that amnion seeded with fibroblasts extracted from the patient's own cells will result in a vagina with the proper size and moisture that can eliminate the need for long-term dilatation. The constructed vagina has a 2-layer structure and is much more resistant to trauma and laceration. No cases of stenosis or stricture were recorded. Level of Evidence = IV. These preliminary findings need to be validated by well-designed studies.

Pitch-Raising Surgery in Transfeminine Persons

Van Damme and colleagues (2017) reviewed the evidence of the effectiveness of pitch-raising surgery performed in male-to-female transsexuals. These investigators carried out a search for studies in PubMed, Web of Science, Science Direct, EBSCOhost, Google Scholar, and the references in retrieved manuscripts, using as keywords "transsexual" or "transgender" combined with terms related to voice surgery. They included 8 studies using cricothyroid approximation, 6 studies using anterior glottal web formation, and 6 studies using other surgery types or a combination of surgical techniques, leading to 20 studies in total. Objectively, a substantial rise in post-operative fundamental frequency was identified. Perceptually, mainly laryngeal web formation appeared risky for decreasing voice quality. The majority of patients appeared satisfied with the outcome. However, none of the studies used a control group and randomization process. The authors concluded that future research needs to investigate long-term effects of pitch-raising surgery using a stronger study design.

Azul and associates (2017) evaluated the currently available discursive and empirical data relating to those aspects of trans-masculine people's vocal situations that are not primarily gender-related, and identified restrictions to voice function that have been observed in this population, and made suggestions for future voice research and clinical practice. These researchers conducted a comprehensive review of the voice literature. Publications were identified by searching 6 electronic databases and bibliographies of relevant articles. A total of 22 publications met inclusion criteria. Discourses and empirical data were analyzed for factors and practices that impact on voice function and for indications of voice function-related problems in trans-masculine people.

The quality of the evidence was appraised. The extent and quality of studies investigating trans-masculine people's voice function was found to be limited. There was mixed evidence to suggest that trans-masculine people might experience restrictions to a range of domains of voice function, including vocal power, vocal control/stability, glottal function, pitch range/variability, vocal endurance, and voice quality. The authors concluded that more research into the different factors and practices affecting trans-masculine people's voice function that took account of a range of parameters of voice function and considered participants' self-evaluations is needed to establish how functional voice production can be best supported in this population.

Facial Feminization Surgery

Raffaini and colleagues (2016) stated that gender dysphoria refers to the discomfort and distress that arise from a discrepancy between a person's gender identity and sex assigned at birth. The treatment plan for gender dysphoria varies and can include psychotherapy, hormone treatment, and gender affirmation surgery, which is, in part, an irreversible change of sexual identity. Procedures for transformation to the female sex include facial feminization surgery, vaginoplasty, clitoroplasty, and breast augmentation. Facial feminization surgery can include forehead re-modeling, rhinoplasty, mentoplasty, thyroid chondroplasty, and voice alteration procedures. These investigators reported patient satisfaction following facial feminization surgery, including outcome measurements after forehead slippage and chin re-modeling. A total of 33 patients between 19 and 40 years of age were referred for facial feminization surgery between January of 2003 and December of 2013, for a total of 180 procedures. Surgical outcome was analyzed both subjectively through questionnaires administered to patients and objectively by serial photographs. Most facial feminization surgery procedures could be safely completed in 6 months, barring complications. All patients showed excellent cosmetic results and were satisfied with their procedures. Both frontal and profile views achieved a loss of masculine features. The authors concluded that patient satisfaction following facial feminization surgery was high; they stated that the reduction of gender dysphoria had psychological and social benefits and significantly affected patient outcome. The level of evidence of this study was IV.

Morrison and associates (2018) noted that facial feminization surgery encompasses a broad range of cranio-maxillofacial surgical procedures designed to change masculine facial features into feminine features. The surgical principles of facial feminization surgery could be applied to male-to-female transsexuals and anyone desiring feminization of the face.

Although the prevalence of these procedures is difficult to quantify, because of the rising prevalence of transgenderism (approximately 1 in 14,000 men) along with improved insurance coverage for gender-confirming surgery, surgeons versed in techniques, outcomes, and challenges of facial feminization surgery are needed. These researchers appraised the current facial feminization surgery literature. They carried out a comprehensive literature search of the Medline, PubMed, and Embase databases was conducted for studies published through October 2014 with multiple search terms related to facial feminization. Data on techniques, outcomes, complications, and patient satisfaction were collected. A total of 15 articles were selected and reviewed from the 24 identified, all of which were either retrospective or case series/reports. Articles covered a variety of facial feminization procedures. A total of 1,121 patients underwent facial feminization surgery, with 7 complications reported, although many articles did not explicitly comment on complications. Satisfaction was high, although most studies did not use validated or quantified approaches to address satisfaction. The authors concluded that facial feminization surgery appeared to be safe and satisfactory for patients. These researchers stated that further studies are needed to better compare different techniques to more robustly establish best practices; prospective studies and patient-reported outcomes are needed to establish quality-of-life (QOL) outcomes for patients.

Reversal of Gender Affirming Surgery for Gender Dysphoria

The WPATH Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming Peoples describe reversible and irreversible interventions, and the ideal order and timing of these approaches. Surgery as an intervention is considered irreversible by WPATH.

Appendix

DSM 5 Criteria for Gender Dysphoria in Adults and Adolescents

- I. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following:
 - A. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
 - B. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
 - C. A strong desire for the primary and/or secondary sex characteristics of the other gender
 - D. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
 - E. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
 - F. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
- II. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Format for referral letters from Qualified Health Professional: (From SOC-7)

1. Client's general identifying characteristics; *and*
2. Results of the client's psychosocial assessment, including any diagnoses; *and*
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date; *and*

4. An explanation that the WPATH criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery; *and*
5. A statement about the fact that informed consent has been obtained from the patient; *and*
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

Note: There is no minimum duration of relationship required with mental health professional. It is the professional's judgment as to the appropriate length of time before a referral letter can appropriately be written. A common period of time is three months, but there is significant variation in both directions. When two letters are required, the second referral is intended to be an evaluative consultation, not a representation of an ongoing long-term therapeutic relationship, and can be written by a medical practitioner of sufficient experience with gender dysphoria.

Note: Evaluation of candidacy for gender affirmation surgery by a mental health professional is covered under the member's medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the member's behavioral health benefit. Please check benefit plan descriptions.

Characteristics of a Qualified Mental Health Professional: (From SOC-7)

1. Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent; *and*
2. Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes; *and*
3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; *and*
4. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; *and*

5. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+".

Code	Code Description
CPT codes covered if selection criteria are met:	
<i>Laser hair removal - no specific code</i>	
17380	Electrolysis epilation, each 30 minutes
19318	Reduction mammoplasty
19324 - 19325	Mammoplasty, augmentation
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400 - 54417	Penile prosthesis
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopic, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	complicated
55970	Intersex surgery; male to female [a series of staged procedures that includes male genitalia removal, penile dissection, urethral transposition, creation of vagina and labia with stent placement]

Code	Code Description
55980	female to male [a series of staged procedures that include penis and scrotum formation by graft, and prostheses placement]
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106 - 57107, 57110 - 57111	Vaginectomy
57291 - 57292	Construction of artificial vagina
57335	Vaginoplasty for intersex state
58150, 58180, 58260 - 58262, 58275 - 58291, 58541 - 58544, 58550 - 58554	Hysterectomy
58570 - 58573	Laparoscopy, surgical, with total hysterectomy
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral
CPT codes not covered for indications listed in the CPB [considered cosmetic]:	
<i>Tracheal shave</i> - no specific code:	
11950 - 11954	Subcutaneous injection of filling material (e.g., collagen)
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less [nipple reconstruction]
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780 - 15787	Dermabrasion

Code	Code Description
15788 - 15793	Chemical peel
15820 - 15823	Blepharoplasty
15824 - 15828	Rhytidectomy [face-lifting]
15830 - 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15876 - 15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303	Mastectomy, simple, complete
19316	Mastopexy
19350	Nipple/areola reconstruction
21087	Nasal prosthesis
21120 - 21123	Genioplasty
21125 - 21127	Augmentation, mandibular body or angle; prosthetic material or with bone graft, onlay or interpositional (includes obtaining autograft)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	with internal rigid fixation
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400 - 30420	Rhinoplasty; primary
30430 - 30450	Rhinoplasty; secondary

Code	Code Description
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals
Other CPT codes related to the CPB:	
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
+90785	Interactive complexity (List separately in addition to the code for primary procedure)
90832 - 90838	Psychotherapy
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance of drug); subcutaneous or intramuscular
HCPSC codes covered if selection criteria are met:	
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable
J1071	Injection, testosterone cypionate, 1 mg
J3121	Injection, testosterone enanthate, 1 mg
J3145	Injection, testosterone undecanoate, 1 mg
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J9202	Goserelin acetate implant, per 3.6 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg
J9219	Leuprolide acetate implant, 65 mg
S0189	Testosterone pellet, 75 mg
HCPSC codes not covered for indications listed in the CPB:	
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
S9128	Speech therapy, in the home, per diem
ICD-10 codes covered if selection criteria are met:	
F64.0 - F64.1	Transsexualism and dual role transvestism

Code	Code Description
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment
ICD-10 codes not covered for indications listed in the CPB:	
F64.2	Gender identity disorder of childhood

The above policy is based on the following references:

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